

# WISCONSIN LONG TERM CARE FUNCTIONAL SCREEN

Resource Center:	Referral Date: mm/dd/yyyy  ____/____/____
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<b>Applicant Name: (Print Clearly)</b>			<b>Date of Birth</b>
Last:	First:	M.I.:	MM/DD/YYYY
Social Security # ____ - ____ - ____		Gender:    • M = Male        • F = Female	

## TARGET GROUP QUESTION

This person has a condition **that is expected to last for more than 90 days related to** (Check ***all*** that apply):

*(Please refer to the definitions on the last page of the screen and to the instructions)*

- ☐ **Infirmities of aging**
- ☐ **Physical disability**
- ☐ **Developmental disability per FEDERAL DEFINITION**
  - ☐ **Developmental disability per STATE definition but NOT federal definition**
- ☐ **Alzheimer's disease or other irreversible dementia (onset of any age)**
- ☐ **A terminal condition with death expected within one year from the date of this screening**

### **RESULTS:**

**At least one of the above boxes above must be checked** to indicate that person is within at least one of the intended "target groups" for Family Care. Continue with the Family Care screen to determine whether the person meets functional eligibility for Family Care.

**If NONE of the above boxes above are checked**, the person is not eligible for Family Care. Provide her/him (or representative) with information and options regarding other health and social services, such as mental health or substance abuse treatment, Family Violence, Elder Abuse, or Adult Protective Services, and other programs and community resources. Also advise them regarding possible eligibility for Medicaid and Medicare services.

**SCREEN TYPE:** Check only **one** box:

- ☐ 01 Initial screen , *not pre-admission as in box 4 below*
- ☐ 02 Annual screen, *not pre-admission as in box 4 below*
- ☐ 03 Screen due to change in condition or situation (or by request)
- ☐ 04 Pre-Admission screen: (*whether first or repeat screen*)
  - ☐ 4a Nursing home
  - ☐ 4b ICF-MR/FDD (Intermediate Care Facility for MR; Facility for DD)
  - ☐ 4c CBRF (Community-Based Residential Facility; group home)
  - ☐ 4d AFH (Adult Family Home)
  - ☐ 4e Home & Community-Based Waiver

**REFERRAL SOURCE:** Check only **one** box:

- 01 Self
- 02 Family/Significant Other
- 03 Friend/Neighbor/Advocate
- 04 Physician/Clinic
- 05 Hospital Discharge Staff
- 06 Nursing Home
- 07 CBRF (Group Home)
- 08 AFH (Adult Family Home)
- 09 RCAC (Residential Care Apartment Complex)
- 10 ICF-MR/FDD
- 11 State Center
- 12 Home Health Agency
- 13 Community Agency
- 14 Other: \_\_\_\_\_(specify)

**PRIMARY SOURCE FOR SCREEN INFORMATION:** Check only **one** box.

- **01 Individual** If other, their name(s): \_\_\_\_\_
- 02 Guardian
- 03 Family Member
- 04 Spouse/Significant Other
- 05 Parent
- 06 Child
- 07 Advocate
- 08 Case Manager
- 09 Hospital Staff
- 10 Nursing Home Staff
- 11 ICF-MR/Center Staff
- 12 CBRF Staff
- 13 AFH Staff
- 14 Home Health, Personal Care, or Supportive Home Care Staff
- 15 Other: \_\_\_\_\_(specify)

**WHERE SCREEN INTERVIEW WAS CONDUCTED:**

- 01 Person's Current Residence
- 02 Temporary Residence (non-institutional)
- 03 Nursing Home
- 04 Hospital
- 05 Other (*e.g. county office, Resource Center*):
- 06 Other: \_\_\_\_\_(specify)

**APPLICANT'S ADDRESS:**

\_\_\_\_\_  
\_\_\_\_\_

Telephone Number: (\_\_\_\_\_)\_\_\_\_\_

County of Residence: \_\_\_\_\_ County of Responsibility: \_\_\_\_\_

**MEDICAL INSURANCE:** Check *all* that apply. Write numbers clearly.

- 01 MEDICARE # \_\_\_\_\_ • PART A • PART B • PART C
- 02 MEDICAL ASSISTANCE # \_\_\_\_\_
- 03 PRIVATE INSURANCE (includes employer-sponsored [job benefit] insurance)
- 04 PRIVATE LONG TERM CARE INSURANCE
- 05 OTHER
- 06 NO MEDICAL INSURANCE AT THIS TIME

**RACE/ETHNICITY:**

- A = Asian or Pacific Islander
- B = Black
- C = Caucasian (white/non-Hispanic)
- M = Multi-racial
- H = Hispanic
- I = American Indian or Alaskan Native
- X = Other: \_\_\_\_\_

☐ **AN INTERPRETER IS REQUIRED. If so, in what language?**

- 01 American Sign Language
- 02 Spanish
- 03 Vietnamese
- 04 Hmong
- 05 Russian
- 06 Other: \_\_\_\_\_
- 07 A Native American Language

☐ **PERSON HAS A LEGAL “GUARDIAN OF PERSON”:**

Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Comments:**

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☐ **PERSON HAS AN ACTIVATED POWER OF ATTORNEY FOR HEALTH CARE:**

Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**CURRENT USUAL RESIDENCE:** *Indicate person's usual place of residence. Check ONLY one box.*

<b>OWN HOME OR APARTMENT</b>	• 01	Alone (Includes person living alone who receives in-home services)
	• 02	With spouse/partner/family
	• 03	With non-relatives/roommates
	• 04	With live-in paid caregiver(s) (Includes service in exchange for room & board)
<b>SOMEONE ELSE'S HOME OR APARTMENT</b>	• 05	Family
	• 06	Non-relative
	• 07	Paid caregiver's home (e.g., 1-2 bed adult family home, or child foster care)
	• 08	Home/apartment for which lease is held by support services provider
<b>APARTMENT WITH SERVICES</b>	• 09	Residential Care Apartment Complex
	• 10	Independent Apartment CBRF (Community-Based Residential Facility)
<b>GROUP RESIDENTIAL CARE SETTING</b>	• 11	Licensed Adult Family Home (3 - 4 bed AFH)
	• 12	CBRF
	• 13	Children's Group Home
<b>HEALTH CARE FACILITY/ INSTITUTION</b>	• 14	Nursing Home
	• 15	FDD/ICF- MR
	• 16	DD Center/State institution for developmental disabilities
	• 17	Mental Health Institute/State psychiatric institution
	• 18	Other IMD
	• 19	Child Caring Institution
<b>NO HOME</b>	• 20	No Permanent Residence (e.g., is in homeless shelter, etc.)
<b>OTHER</b>	• 21	Specify: _____

1. Where would this person like to live? Record the person's preference, not what is deemed realistic (safe, cost-effective, etc.), and not what the family/guardian want.

- ☐ 01 Stay at current residence
- ☐ 02 Move to own home/apartment (Includes living with spouse, roommates)
- ☐ 03 Move to an apartment with onsite services (RCAC, independent apartment CBRF)
- ☐ 04 Move to someone else's home (e.g., family's, 1-2 bed AFH)
- ☐ 05 Move to a group residential care setting (CBRF, licensed 3-4 bed AFH)
- ☐ 06 Move to a nursing home or other health care facility (ICF-MR, State Center, IMD)
- ☐ 07 Wants to move, but not sure where
- ☐ 08 Unsure, or unable to determine

2. What is the guardian's/family's preference for living arrangement for this individual?

- ☐ 0 Not Applicable
- ☐ 01 Stay at current residence
- ☐ 02 Move to own home/apartment (Includes living with spouse, roommates)
- ☐ 03 Move to an apartment with onsite services (RCAC, independent apartment CBRF)
- ☐ 04 Move to someone else's home (e.g., family's, 1-2 bed AFH)
- ☐ 05 Move to a group residential care setting (CBRF, licensed 3-4 bed AFH)
- ☐ 06 Move to a nursing home or other health care facility (ICFMR, State Center, IMD)
- ☐ 07 Wants to move, but not sure where
- ☐ 08 Unsure, or unable to determine
- ☐ 09 No consensus among multiple parties

## Module II: ADLs and IADLs

### DETAILS OF LEVEL OF HELP NEEDED TO COMPLETE TASK SAFELY:

<b>0</b>	<b>Person is independent in completing the activity safely</b>
<b>1</b>	Help is needed to complete task safely but helper <u>DOES NOT</u> have to be physically present throughout the task. "Help" can be supervision, cueing, or hands-on assistance
<b>2</b>	Help is needed to complete task safely and helper <u>DOES</u> need to be present throughout task. Help can be supervision, cueing, and/or hands-on assistance (partial or complete)

### CODING FOR WHO WILL HELP IN NEXT 8 WEEKS: Check **all** that apply.

<b>U</b>	Current <b>UNPAID</b> caregiver will continue
<b>PP</b>	Current <b>PRIVATELY PAID</b> caregiver will continue
<b>PF</b>	Current <b>PUBLICLY FUNDED</b> paid caregiver will continue
<b>N</b>	<b>Need</b> to find new or additional caregiver(s)

<b>ADLs (Activities of Daily Living)</b>	<b>Help Needed Check only one</b>	<b>Who Will Help in Next 8 weeks Check all that apply</b>
<b>BATHING</b> The ability to shower, bathe or take sponge baths for the purpose of maintaining adequate hygiene. This also includes the ability to get in and out of the tub, turn faucets on & off, regulate water temperature, wash and dry fully. <input type="checkbox"/> <b>USES SHOWER CHAIR, TUB BENCH, OR GRAB BARS</b>	<input type="checkbox"/> <b>0</b> <input type="checkbox"/> <b>1</b> <input type="checkbox"/> <b>2</b>	<input type="checkbox"/> <b>U</b> <input type="checkbox"/> <b>PP</b> <input type="checkbox"/> <b>PF</b> <input type="checkbox"/> <b>N</b>
<b>DRESSING</b> The ability to dress and undress as necessary and choose appropriate clothing. Includes the ability to put on prostheses, braces, antiembolism hose (e.g., "TED stockings") or assistive devices, and includes fine motor coordination for buttons and zippers. <i>(Includes choice of clothing appropriate for the weather. Difficulties with a zipper or buttons <b>at the back</b> of a dress or blouse do not constitute a functional deficit.)</i>	<input type="checkbox"/> <b>0</b> <input type="checkbox"/> <b>1</b> <input type="checkbox"/> <b>2</b>	<input type="checkbox"/> <b>U</b> <input type="checkbox"/> <b>PP</b> <input type="checkbox"/> <b>PF</b> <input type="checkbox"/> <b>N</b>
<b>EATING</b> The ability to eat and drink using routine or adaptive utensils. This also includes the ability to cut, chew, and swallow food. <i>Note: If person is fed via tube feedings or intravenous, check box 0 if they can do themselves, or box 1 or 2 if they require another person to assist.</i>	<input type="checkbox"/> <b>0</b> <input type="checkbox"/> <b>1</b> <input type="checkbox"/> <b>2</b>	<input type="checkbox"/> <b>U</b> <input type="checkbox"/> <b>PP</b> <input type="checkbox"/> <b>PF</b> <input type="checkbox"/> <b>N</b>
<b>MOBILITY IN HOME</b> The ability to move between locations in the individual's living environment—defined as kitchen, living room, bathroom, and sleeping area. <i>For purposes of the functional screen, this excludes basements, attics and yards.</i> <input type="checkbox"/> <b>WALKER OR QUAD-CANE FOR USE IN HOME</b> <input type="checkbox"/> <b>WHEELCHAIR OR SCOOTER FOR USE IN HOME</b> <input type="checkbox"/> <b>HAS PROSTHESIS</b>	<input type="checkbox"/> <b>0</b> <input type="checkbox"/> <b>1</b> <input type="checkbox"/> <b>2</b>	<input type="checkbox"/> <b>U</b> <input type="checkbox"/> <b>PP</b> <input type="checkbox"/> <b>PF</b> <input type="checkbox"/> <b>N</b>

<b>ADLs (Activities of Daily Living)</b> <i>(Continued)</i>	<b>Help Needed</b> <i>Check only one</i>	<b>Who Will Help in Next 8 weeks</b> <i>Check all that apply</i>
<p><b>TOILETING</b> The ability to use the toilet, commode, bedpan, or urinal. This includes transferring on/off the toilet, cleansing of self, changing of pads, managing an ostomy or catheter, and adjusting clothes.</p> <p> <input type="checkbox"/> <b>USES COMMODE</b>  <input type="checkbox"/> <b>HAS OSTOMY</b>  <input type="checkbox"/> <b>USES URINARY CATHETER</b>  <input type="checkbox"/> <b>RECEIVES REGULAR BOWEL PROGRAM</b>  <input type="checkbox"/> <b>WEARS (OR SHOULD WEAR ) INCONTINENCE PRODUCTS</b> </p>	<input type="checkbox"/> <b>0</b> <input type="checkbox"/> <b>1</b> <input type="checkbox"/> <b>2</b>	<input type="checkbox"/> <b>U</b> <input type="checkbox"/> <b>PP</b> <input type="checkbox"/> <b>PF</b> <input type="checkbox"/> <b>N</b>
<p><b>TRANSFERRING</b> The physical ability to move between surfaces: from bed/chair to wheelchair, walker or standing position. The ability to get in and out of bed or usual sleeping place. The ability to use assistive devices for transfers. <u>Excludes</u> toileting transfers.</p> <p> <input type="checkbox"/> <b>USES MECHANICAL LIFT</b> <i>(not a lift chair)</i>  <input type="checkbox"/> <b>USES TRANSFER BOARD OR TRAPEZE</b> </p>	<input type="checkbox"/> <b>0</b> <input type="checkbox"/> <b>1</b> <input type="checkbox"/> <b>2</b>	<input type="checkbox"/> <b>U</b> <input type="checkbox"/> <b>PP</b> <input type="checkbox"/> <b>PF</b> <input type="checkbox"/> <b>N</b>

## IADLs – INSTRUMENTAL ACTIVITIES OF DAILY LIVING

### DEFINITIONS OF IADLS

**MEAL PREPARATION:** The ability to obtain and prepare routine meals. This includes the ability to independently open containers and use kitchen appliances, with assistive devices if uses them. *If the person is fed via tube feedings or intravenous, treat preparation of the tube feeding as “meal prep,” and indicate level of help needed.*

**MONEY MANAGEMENT:** The ability to handle money, pay bills, plan, budget, write checks or money orders, exchange currency, handle coins and paper work, i.e., to do financial management for basic necessities (food, clothing, shelter).

**TELEPHONE:** The ability to dial, answer, and use phone, with assistive devices if uses them.

**CODING FOR WHO WILL HELP IN NEXT 8 WEEKS:** *Check all that apply.*

<b>U</b>	Current UNPAID caregiver will continue
<b>PP</b>	Current PRIVATELY PAID caregiver will continue
<b>PF</b>	Current PUBLICLY FUNDED paid caregiver will continue
<b>N</b>	Need to find new or additional caregiver(s)

IADL	Level of Help Needed	Who will help in next 8 wks?
<b>MEAL PREPARATION</b>	<input type="checkbox"/> 0 Independent <input type="checkbox"/> 1 Needs help from another person weekly or less often <input type="checkbox"/> 2 Needs help 2 to 6 times a week—(to prepare or help with meal preparation or provide meals) <input type="checkbox"/> 3 Needs help with every meal (to provide, prepare or help prepare)	<input type="checkbox"/> U <input type="checkbox"/> PP <input type="checkbox"/> PF <input type="checkbox"/> N
<b>MANAGEMENT OF MEDS &amp;/OR TREATMENTS</b>	<input type="checkbox"/> NA - Has no medications or treatments <input type="checkbox"/> 0 Independent (with or without assistive devices) <input type="checkbox"/> 1 Needs help weekly or less <i>Includes having someone set up meds (e.g., in blister packs or med box) or pre-filling syringes, or administration of medicine or treatment weekly or less</i> <input type="checkbox"/> 2 Needs help approximately DAILY or more often: <i>If so, indicate:</i> <div style="margin-left: 20px;"> <input type="checkbox"/> a. Person CAN DIRECT the task and can make decisions regarding each med or treatment  <input type="checkbox"/> b. Person CANNOT direct the task; is cognitively unable to follow through without another person to administer each med or treatment           </div>	<input type="checkbox"/> U <input type="checkbox"/> PP <input type="checkbox"/> PF <input type="checkbox"/> N
<b>MONEY MANAGEMENT</b>	<input type="checkbox"/> 0 Independent <input type="checkbox"/> 1 Needs help from another person weekly or less <input type="checkbox"/> 2 Needs help from another person daily or more often ( <i>e.g., with every transaction</i> )	<input type="checkbox"/> U <input type="checkbox"/> PP <input type="checkbox"/> PF <input type="checkbox"/> N
<b>LAUNDRY &amp;/OR CHORES</b>	<input type="checkbox"/> 0 Independent <input type="checkbox"/> 1 Needs help from another person weekly or less often <input type="checkbox"/> 2 Needs help more than once a week  <i>Chores = Housekeeping, home maintenance, shoveling, etc.</i>	<input type="checkbox"/> U <input type="checkbox"/> PP <input type="checkbox"/> PF <input type="checkbox"/> N
<b>TELEPHONE</b>	<b>1. Ability to Use Phone:</b> <input type="checkbox"/> 1a Independent. Has cognitive and physical abilities to make calls and answer calls (with assistive devices currently used by this person) <input type="checkbox"/> 1b Lacks cognitive or physical abilities to use phone independently <b>2. Access to Phone:</b> <input type="checkbox"/> 2a Currently has working telephone or access to one <input type="checkbox"/> 2b Has no phone and no access to phone	

## TRANSPORTATION

☐ **1 Person drives:**

- ☐ 1a Person drives regular vehicle
- ☐ 1b Person drives adapted vehicle

*May also check to indicate if appropriate:*

- ☐ 1c Person drives but there are serious safety concern

☐ **2 Person can not drive due to physical or cognitive impairment.** (Includes people who cannot get a drivers' license due to medical problems (e.g., seizures, poor vision))

☐ **3 Person does not drive due to other reasons.** (e.g., has no license, but not due to physical or cognitive impairment, or has no car)

**EMPLOYMENT:** The ability to function at a job site. *This question concerns the need for employment-related assistance. Since the need for help with ADLs and IADLs is captured in other sections, this question essentially covers job coach duties.*

<b>A. EMPLOYMENT STATUS</b>	<input type="checkbox"/> 1 Employed <input type="checkbox"/> 2 Not employed or under-employed and interested in new job <input type="checkbox"/> 3 Retired, or not employed and not interested in employment
<b>B. IF EMPLOYED, WHERE</b>	<input type="checkbox"/> 1 Attends pre-vocational day activity/work activity program <input type="checkbox"/> 2 Attends sheltered workshop <input type="checkbox"/> 3 Has a paid job in the community <input type="checkbox"/> 4 Works at home
<b>C. NEED FOR ASSISTANCE TO WORK (OPTIONAL FOR UNEMPLOYED PERSONS)</b>	<input type="checkbox"/> 0 Independent (with assistive devices if uses them) <input type="checkbox"/> 1 Needs help weekly or less (e.g., if problems arise) <input type="checkbox"/> 2 Needs help every day but does not need the continuous presence of another <input type="checkbox"/> 3 Needs the continuous presence of another person

## **DOES PERSON REQUIRE OVERNIGHT CARE OR SUPERVISION?**

- ☐ 0 No
- ☐ 1 Yes; caregiver can get at least 6 hours of uninterrupted sleep per night
- ☐ 2 Yes; caregiver cannot get at least 6 hours of uninterrupted sleep per night

## MODULE III A: DIAGNOSES

**Diagnoses:** Check diagnosis here if (1) it is provided by a health care provider, or (2) you see it written in a medical record (including hospital discharge forms, nursing home admission forms, etc.), or (3) if person or informant can state them **EXACTLY** -- except for psychiatric diagnoses, which must be confirmed by health care personnel or records. Do not try to interpret people's complaints or medical histories. Contact health providers instead.

<b>A. DEVELOPMENTAL DISABILITY</b>		<input type="checkbox"/> 9 Other Neurological or Neuro-Motor Disorders
<input type="checkbox"/> 1 Mental Retardation		<input type="checkbox"/> 10 Spina Bifida
<input type="checkbox"/> 2 Autism		<input type="checkbox"/> 11 Seizure Disorder <b>with onset after age 22</b>
<input type="checkbox"/> 3 Brain Injury <b>with onset before age 22</b>		<b>F. RESPIRATORY</b>
<input type="checkbox"/> 4 Cerebral Palsy		<input type="checkbox"/> 1 Asthma/Chronic Obstructive Pulmonary Disease (COPD)/Emphysema/Chronic Bronchitis
<input type="checkbox"/> 5 Prader-Willi Syndrome		<input type="checkbox"/> 2 Pneumonia/Acute Bronchitis/Influenza
<input type="checkbox"/> 6 Seizure Disorder <b>with onset before age 22</b>		<input type="checkbox"/> 3 Tracheostomy
<input type="checkbox"/> 7 Otherwise meets state or federal definitions of DD		<input type="checkbox"/> 4 Ventilator Dependent
<b>B. ENDOCRINE/METABOLIC</b>		<input type="checkbox"/> 5 Other Respiratory Condition
<input type="checkbox"/> 1 Diabetes Mellitus		<b>G. DISORDERS OF GENITOURINARY SYSTEM/REPRODUCTIVE SYSTEM</b>
<input type="checkbox"/> 2 Hypothyroidism/Hyperthyroidism		<input type="checkbox"/> 1 Renal Failure, other Kidney Disease
<input type="checkbox"/> 3 Nutritional Deficiencies/Dehydration/Fluid & Electrolyte Imbalances		<input type="checkbox"/> 2 Other Disorders of GU System ( <i>bladder, ureters, urethra</i> )
<input type="checkbox"/> 4 Liver Disease ( <i>hepatic failure, cirrhosis</i> )		<input type="checkbox"/> 3 Disorders of Reproductive System
<input type="checkbox"/> 5 Other Disorders of Digestive System ( <i>mouth, esophagus, stomach, intestines, gall bladder, pancreas</i> )		<b>H. DOCUMENTED MENTAL ILLNESS</b>
<input type="checkbox"/> 6 Other disorders of Hormonal/or Metabolic System		<input type="checkbox"/> 1 Anxiety Disorder ( <i>phobias, post-traumatic stress disorder, obsessive-compulsive disorder</i> )
<b>C. HEART/CIRCULATION</b>		<input type="checkbox"/> 2 Bipolar/Manic-Depressive
<input type="checkbox"/> 1 Anemia/Coagulation Defects/Other Blood Diseases		<input type="checkbox"/> 3 Depression
<input type="checkbox"/> 2 Angina/Coronary Artery Disease/Myocardial Infarction ( <i>M.I.</i> )		<input type="checkbox"/> 4 Schizophrenia
<input type="checkbox"/> 3 Disorders of Heart Rate or Rhythm		<input type="checkbox"/> 5 Other <b>Psychiatric</b> Diagnosis/Personality Disorder
<input type="checkbox"/> 4 Congestive Heart Failure ( <i>CHF</i> )		<b>I. SENSORY</b>
<input type="checkbox"/> 5 Disorders of Blood Vessels or Lymphatic System		<input type="checkbox"/> 1 Blind
<input type="checkbox"/> 6 Hypertension ( <i>HTN</i> ) ( <i>high blood pressure</i> )		<input type="checkbox"/> 2 Deaf
<input type="checkbox"/> 7 Hypotension ( <i>low blood pressure</i> )		<input type="checkbox"/> 3 Other Sensory Disorders
<input type="checkbox"/> 8 Other heart conditions ( <i>including valve disorders</i> )		<b>J. INFECTIONS/IMMUNE SYSTEM</b>
<b>D. MUSCULOSKELETAL</b>		<input type="checkbox"/> 1 Allergies
<input type="checkbox"/> 1 Amputation		<input type="checkbox"/> 2 Cancer in Past 5 Years
<input type="checkbox"/> 2 Arthritis		<input type="checkbox"/> 3 Diseases of Skin
<input type="checkbox"/> 3 Hip Fracture/Replacement		<input type="checkbox"/> 4 HIV – Positive
<input type="checkbox"/> 4 Other Fracture/Joint Disorders		<input type="checkbox"/> 5 AIDS Diagnosed
<input type="checkbox"/> 5 Osteoporosis/Other Bone Disease/Scoliosis/Kyphosis/Spinal Disorders ( <i>including back pain</i> )		<input type="checkbox"/> 6 Other Infectious Disease
<input type="checkbox"/> 6 Contractures/Connective Tissue Disorders		<input type="checkbox"/> 7 Auto-Immune Disease (besides rheumatism)
<b>E. NEUROLOGICAL/NEUROMUSCULAR</b>		<b>K. OTHER</b>
<input type="checkbox"/> 1 Alzheimer's Disease		<input type="checkbox"/> 1 Alcohol or Drug Abuse
<input type="checkbox"/> 2 Other <u>Irreversible</u> Dementia		<input type="checkbox"/> 2 Behavioral Diagnoses ( <i>not found in Part H above</i> )
<input type="checkbox"/> 3 Cerebral Vascular Accident ( <i>CVA, stroke</i> )		<input type="checkbox"/> 3 Terminal Illness ( <i>prognosis ≤ 12 months</i> )
<input type="checkbox"/> 4 Traumatic Brain Injury <b>AFTER age 22</b>		<input type="checkbox"/> 4 Wound/Burn/Bedsore/Pressure Ulcer
<input type="checkbox"/> 5 Multiple Sclerosis/ALS		<input type="checkbox"/> <b>5 OTHER:</b>
<input type="checkbox"/> 6 Muscular Dystrophy		
<input type="checkbox"/> 7 Spinal Cord Injury		
<input type="checkbox"/> 8 Paralysis Other than Spinal Cord Injury		

## MODULE III Part B: HEALTH-RELATED SERVICES: *Check only **one** box per row.*

HEALTH-RELATED SERVICES NEEDED	PERSON IS INDEPENDENT	FREQUENCY OF HELP/SERVICES NEEDED FROM OTHER PERSONS				
		Weekly or less often	2 to 6 days/ week	1 to 2 times a day	3 to 4 times a day	Over 4 times a day
INTERVENTIONS related to <b>BEHAVIORS</b>						
<b>CONDITION</b> - REQUIRES NURSING ASSESSMENT or skilled medical monitoring by persons trained and overseen by nurse. Condition may be unstable or deteriorating (e.g., infections, gangrene, dehydration, malnutrition, terminal condition, exacerbation, AIDS, etc.), and/or result from multiple health risks in person unable to manage them or to communicate problems.						
IV CHEMOTHERAPY						
<b>EXERCISES/RANGE OF MOTION</b>						
IV FLUIDS						
IV MEDICATIONS (DRIPS OR BOLUSES not chemotherapy)						
MEDICATION ADMINISTRATION (not IV) OR ASSISTANCE with pre-selected or set-up meds.						
MEDICATION MANAGEMENT – SET-UP &/or MONITORING (for effects, side effects, adjustments) -- AND/OR BLOOD LEVELS						
OSTOMY–RELATED <u>SKILLED</u> SERVICES						
OXYGEN						
<u>PAIN MANAGEMENT</u>						
POSITIONING IN BED OR CHAIR every 2-3 hours						
RESPIRATORY THERAPY: NEBULIZERS, IPPB TREATMENTS, BI-PAP, C-PAP; (does NOT include inhalers)						
IN-HOME DIALYSIS						
TPN (TOTAL PARENTERAL NUTRITION)						
TRANSFUSIONS						
TRACHEOSTOMY CARE						
TUBE FEEDINGS						
ULCER –STAGE 2						
ULCER—STAGE 3 OR 4						
URINARY CATHETER-RELATED <u>SKILLED</u> TASKS (irrigation, straight caths)						
OTHER <b>WOUND</b> CARES (NOT CATH SITES, OSTOMY SITES, OR IVs)						
VENTILATOR–RELATED INTERVENTIONS						
OTHER: <i>write in:</i>						
SKILLED THERAPIES – PT, OT, ST (Any one or a combination, at any location )		5 + days/week		1 to 4 days/week		

**Coding for who will help with all health-related needs in next 8 weeks (check all that apply):**

- ☐ **U** Current UNPAID caregiver will continue
- ☐ **PP** Current PRIVATELY PAID caregiver will continue
- ☐ **PF** Current PUBLICLY FUNDED paid caregiver will continue
- ☐ **N** Need to find new (or additional) caregiver

## MODULE IV: COMMUNICATION AND COGNITION

### **COMMUNICATION:** Check only one box.

Includes the ability to express oneself in one's own language: including non-English languages and American Sign Language (ASL) (or other generally recognized non-verbal communication). This includes the use of assistive technology.

- ☐ 0 Can fully communicate with no impairment or only minor impairment (e.g., slow speech)
- ☐ 1 Can fully communicate with the use of assistive device
- ☐ 2 Can communicate **ONLY BASIC** needs to others
- ☐ 3 No effective communication

### **MEMORY:** Check all that apply.

- ☐ 0 No memory impairments evident during screening process
- ☐ 1 Short Term Memory Loss (seems unable to recall things a few minutes later)
- ☐ 2 Unable to remember things over several days or weeks
- ☐ 3 Long term Memory Loss (seems unable to recall distant past)

### **COGNITION FOR DAILY DECISION MAKING:** Check only one. (BEYOND MEDICATIONS AND FINANCES, which are captured elsewhere)

- ☐ 0 **INDEPENDENT** - Person can make decisions that are generally consistent with her/his own lifestyle, values, and goals (not necessarily with professionals' values and goals)
- ☐ 1 Person can make safe decisions in **FAMILIAR/ROUTINE SITUATIONS**, but needs some help with decision-making when faced with new tasks or situations
- ☐ 2 Person needs help with reminding, planning, or adjusting routine, **EVEN WITH FAMILIAR ROUTINE**
- ☐ 3 Person **NEEDS HELP** from another person most or all of the time

### **PHYSICALLY RESISTIVE TO CARE:** Check only one.

- ☐ 0 No
- ☐ 1 Yes, person is physically resistive to cares due to a cognitive impairment
- ☐ 2 Unknown

# MODULE V: BEHAVIORS/MENTAL HEALTH

**WANDERING:** Defined as a person with cognitive impairments leaving residence/immediate area without informing others. *(Person may still exhibit wandering behavior even if elopement is impossible due to, for example, facility security systems.)*

- ☐ 0 Does not wander
- ☐ 1 Daytime wandering but sleeps nights
- ☐ 2 Wanders at night or day and night

**SELF- INJURIOUS BEHAVIORS:** Behaviors that cause or could cause injury to one's own body. Examples include physical self-abuse (hitting, biting, head banging etc.), pica (eating inedible objects), and water intoxication (polydipsia).

- ☐ 0 No injurious behaviors demonstrated
- ☐ 1 Some self-injurious behaviors require interventions on a weekly or less frequent basis
- ☐ 2 Self-injurious behaviors require interventions every day, but not always 1-on-1
- ☐ 3 Self-injurious behaviors require intensive 1-on-1 interventions almost every waking hour

**OFFENSIVE OR VIOLENT BEHAVIOR TO OTHERS:** Behavior that causes pain or distress to others or interferes with activities of others.

- ☐ 0 No offensive or violent behaviors demonstrated
- ☐ 1 Some offensive or violent behaviors which require occasional interventions **weekly or less**
- ☐ 2 Offensive or violent behaviors which require interventions **every day**, but not always 1-on-1
- ☐ 3 Offensive or violent behaviors that require intensive 1-on-1 interventions most awake hours

## **MENTAL HEALTH NEEDS:**

### **NO KNOWN DIAGNOSIS OF MENTAL ILLNESS:**

- ☐ 0 No mental health problems or needs evident *(no symptoms that may be indicative of mental illness; not on any medications for psychiatric diagnosis)*
- ☐ 1 Person may be at risk and in need of some mental health services. *Examples could include symptoms or reports of problems that may related to mental illness, or requests for help by the person or family/advocates, or risk factors for mental illness. (Examples of risk factors: symptoms of clinical depression that have lasted more than 2 weeks and/or interfere with daily life; recent trauma or loss)*

### **PERSON HAS CURRENT DIAGNOSIS OF MENTAL ILLNESS:**

- ☐ 2 Is currently stable (with or without medications). *"Stable" here means the person is functioning well with routine periodic oversight/support, and is currently receiving such oversight/support.*
- ☐ 3 Is currently not stable. *Needs intensive mental health services (whether they're currently getting them or not, they need them)*

**SUBSTANCE ABUSE:** *More than one box may be checked if appropriate.*

- ☐ 0 No active substance abuse problems evident at this time.
- ☐ 1 Person or others indicate(s) a current problem, or evidence suggests possibility of a current problem or high likelihood of recurrence without significant on-going support or interventions.
- ☐ 2 In the past year, the person has had significant problems due to substance abuse. *(Examples: police interventions, detox, inpatient treatment, job loss, major life changes)*

# MODULE VI: RISK

## PART A - CURRENT APS OR EAN CLIENT:

- ☐ **A1 Person is known to be a current client of Adult Protective Services (APS)**
- ☐ **A2 Person is currently being served by the lead Elder Abuse and Neglect (EAN) agency**  
*(Refer to local APS unit to determine whether this EAN client has current APS needs for eligibility purposes)*

## PART B – RISK EVIDENT DURING SCREENING PROCESS: *Check any that apply.*

- ☐ **0 No risk factors or evidence of abuse or neglect apparent at this time**
- ☐ **1 The individual is currently failing or is at high risk of failing to obtain nutrition, self-care, or safety adequate to avoid significant negative health outcomes**
- ☐ **2 The person is at imminent risk of institutionalization if s/he does not receive needed assistance**
- ☐ **3 There are statements of or evidence of possible abuse, neglect, self-neglect, or financial exploitation**  
**If yes:** ☐ Referring to APS and/or EAN now  
☐ Not referring at this time, because competent adult refuses to allow referral  
*Comments:* \_\_\_\_\_
- ☐ **4 The person's support network appears to be adequate at this time, but may be fragile in the near future (within next 4 months)**

**Is person eligible for Grandfathering into Family Care (per county list)?**

- ☐ **Yes**
- ☐ **No**

<b>SCREENER FOR ALL PRECEDING FUNCTIONAL MODULES:</b> _____		<b>DATE FUNCTIONAL MODULES COMPLETED:</b> ____/____/____
<b>TIME TO COMPLETE THIS PART OF SCREEN: <i>In 15-minute increments (0, 15, 30, or 45)</i></b>		
<b>FACE-TO-FACE CONTACT WITH THE PERSON:</b> <i>(This can include an in-person interview, or observation if person cannot participate in interview)</i>		<b>TOTAL TIME TO COMPLETE FUNCTIONAL (NOT FINANCIAL) PART OF SCREEN:</b>  _____Hrs _____Mins
<b>COLLATERAL CONTACTS:</b> <i>(Either in-person or indirect contact with any other people, including family, advocates, providers, etc.)</i>		
<b>PAPER WORK:</b> <i>(Includes review of medical documents, COP assessment, etc.)</i>		
<b>TRAVEL TIME:</b>		
_____Hrs _____Mins	_____Hrs _____Mins	_____Hrs _____Mins
_____Hrs _____Mins	_____Hrs _____Mins	
_____Hrs _____Mins	_____Hrs _____Mins	
_____Hrs _____Mins	_____Hrs _____Mins	

# WI LONG TERM CARE FUNCTIONAL SCREEN

## Module VII: Financial Information -- Client Cost Share

Participant's Name:

### PRE-SCREEN INCOME ESTIMATION

SINGLE:		COUPLE OR FAMILY:	
<input type="checkbox"/>	Under \$8,000	<input type="checkbox"/>	Under \$11,000
<input type="checkbox"/>	\$8,000--\$14,999	<input type="checkbox"/>	\$11,000--\$14,999
<input type="checkbox"/>	\$15,000--\$24,999	<input type="checkbox"/>	\$15,000--\$24,999
<input type="checkbox"/>	\$25,000--\$39,999	<input type="checkbox"/>	\$24,000--\$39,999
<input type="checkbox"/>	\$40,000 or higher	<input type="checkbox"/>	\$40,000 or higher

### PART 1.

#### A. SSI / MEDICAID STATUS

- |   |                                   |
|---|-----------------------------------|
| 1.a <b>CHECK</b> if person is receiving SSI cash benefit. If so, enter zero on line 29 (client's cost sharing). | <input type="checkbox"/> 1A. Yes  |
| 1.b <b>CHECK</b> if person is receiving Medicaid but not SSI. If so, enter zero on line 9, and continue.        | <input type="checkbox"/> 1 B. Yes |

*If neither Medicaid nor SSI is checked, continue with next section to determine eligibility.*

#### B. Eligibility Based on Twelve-month Resource Estimate Assets of Participant without Spouse:

2. ENTER the estimated total of cash on hand plus amounts in checking and savings accounts plus value of stocks and securities plus the estimated cash value of life insurance.	2												
3. ENTER estimated value of countable property. (See Instructions)	3												
4. ADD the amounts in 2-3.	4												
5. SPOUSAL ALLOWANCE: If applicant has spouse living in own residence, enter allowance according to the following schedule.													
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%; padding: 5px;">If couple's total countable assets are:</td> <td style="width: 40%; padding: 5px;"><b>THEN allowance is:</b></td> <td style="width: 20%; text-align: center; padding: 5px;">5</td> </tr> <tr> <td style="padding: 5px;">a. \$168,240 or more</td> <td style="padding: 5px;">a. \$84,120</td> <td></td> </tr> <tr> <td style="padding: 5px;">b. Less than \$168,240, but greater than \$100,000</td> <td style="padding: 5px;">b. One-half of couple's total countable assets</td> <td></td> </tr> <tr> <td style="padding: 5px;">c. \$100,000 or less</td> <td style="padding: 5px;">c. \$50,000</td> <td></td> </tr> </table>	If couple's total countable assets are:	<b>THEN allowance is:</b>	5	a. \$168,240 or more	a. \$84,120		b. Less than \$168,240, but greater than \$100,000	b. One-half of couple's total countable assets		c. \$100,000 or less	c. \$50,000		
If couple's total countable assets are:	<b>THEN allowance is:</b>	5											
a. \$168,240 or more	a. \$84,120												
b. Less than \$168,240, but greater than \$100,000	b. One-half of couple's total countable assets												
c. \$100,000 or less	c. \$50,000												
6. Subtract line 5 from line 4.	6												
7. SUBTRACT a \$9,000 allowance from line 6 if participant will be living in an out-of-home placement.	7												
8. SUBTRACT a \$12,000 allowance from line 6 if participant will be living in his or her own residence. If the result is zero, enter zero.	8												
9. MULTIPLY line 7 or 8 by 0.0833 to determine portion of assets to be added to income each month for 12 months.	9												

#### C. Income of Person(s) Applying for LTC Service Funding

10. ENTER participant's after-tax monthly income from current employment.	10
11. ENTER \$200 of earnings plus 2/3 of remaining after tax earnings, or \$1250, whichever is less.	11
12. SUBTRACT line 11 from line 10 to find countable income from current employment.	12
13. ENTER all other monthly income (Soc. sec., net rent, pensions, interest, etc.).	13
14. ADD lines 12 and 13 to find <b>TOTAL COUNTABLE MONTHLY INCOME.</b>	14

### PART 2. PARTICIPANT SHARE

15. COPY the asset amount from line 9 in PART 1.	15
16. COPY income from line 14.	16

17. Enter all UNEARNED monthly income of dependent children (dependent as defined in tax code) except means-tested or social security payments. Leave out EARNED income of these children.	17
18. ADD lines 15 through 17 to determine monthly resources.	18
19. Spousal Income Allowance (See instructions)	19
20. Allowance for children & other dependents living in the home. The number of dependents is _____ times \$461 = For each child who lives outside participant's home, multiply \$461 by the proportion of time child is in participant's home.	20
21. Enter average out-of-pocket medically and remedial related expenses anticipated when LTC case plan is in effect. (See instructions for definition of medically and remedial related)	21
22. Enter court-ordered payments paid by participant.	22
23. Enter other Cost share amount(s) to public or private programs paid by participant (See instructions).	23
24. Enter allowance for housing maintenance when in out-of-home placement. (See instructions.)	24
25. A. If living in own residence, ENTER \$692 as a personal maintenance allowance OR enter actual monthly personal maintenance costs, if between \$692 and \$1000. (See instructions.) Do not enter more than \$1000. B. If living in an out-of-home placement, enter \$65.	25
26. Total of lines 19 through 25.	26
27. SUBTRACT line 26 from line 18 to find monthly resources available for cost sharing allowed by the State.	27
28. Enter any special allowance(s) authorized by DHFS for the individual.	28
29. SUBTRACT line 28 from line 27. Use this amount as the Maximum Monthly Participant Contribution.	29

<b>SCREENER FOR FINANCIAL MODULE:</b> _____		DATE: ____/____/____
<b>TIME TO COMPLETE FINANCIAL MODULE:</b> <i>In hours and minutes, rounded to nearest 15 minute increments (0, 15, 30, or 45 minutes).</i>		
<b>FACE-TO-FACE CONTACT WITH THE PERSON:</b> _____  <b>COLLATERAL CONTACTS:</b> <i>(Either in-person or indirect contact with any other people, including family, advocates, providers, etc.)</i>		<b>TOTAL TIME TO COMPLETE FINANCIAL PART OF SCREEN:</b>          _____ HOURS
<b>PAPER WORK:</b> _____		
<b>TRAVEL TIME:</b> _____		

## Definitions for Target Group Question

**INFIRMITIES OF AGING** means organic brain damage caused by advanced age or other physical degeneration in connection therewith to the extent that the person so afflicted is substantially impaired in his or her ability to adequately provide for his or her care or custody” (WI Statutes 55.01(3)).

**DEMENTIA** means Alzheimers’ disease and other related irreversible dementias involving degenerative disease of the central nervous system characterized especially by premature senile mental deterioration and also includes any other irreversible deterioration of intellectual faculties with concomitant emotional disturbance resulting from organic brain disorder (WI Statutes 46.87(1)(a)).

**PHYSICAL DISABILITY** means a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, which results from injury, disease or congenital disorder and which significantly interferes with or significantly limits at least one major life activity of a person” (WI Statutes 15.197(4)(a) 2).

**“Major life activity”** means any of the following: A. Self-care. B. Performance of manual tasks unrelated to gainful employment. C. Walking, D. Receptive and expressive language, E. Breathing, F. Working, G. Participating in educational programs, H. Mobility, other than walking, I. Capacity for independent living.” (WI Statutes 15.197(4)(a)1).

**FEDERAL DEFINITION OF DEVELOPMENTAL DISABILITY:** A person is considered to have mental retardation if he or she has – (i) A level of retardation described in the American Association on Mental Retardation’s Manual on Classification in Mental Retardation , or (ii) A related condition as defined by 42 CFR 425.1009 which states, “Person with related conditions” means individuals who have a severe, chronic disability that meets all of the following conditions:

- (a) It is attributable to—
  - (1) Cerebral palsy or epilepsy or
  - (2) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.
- (b) It is manifested before the person reaches age 22
- (c) It is likely to continue indefinitely
- (d) It results in substantial functional limitations in three or more of the following areas of major like activity: Self-care; Understanding and use of language; learning; mobility; self-direction; or capacity for independent living.

**STATE DEFINITION OF DEVELOPMENTAL DISABILITY:** “‘Developmental disability’ means a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome, mental retardation, or another neurological condition closely related to mental retardation or requiring treatment similar to that required for mental retardation, which has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual. ‘Developmental disability’ does not include senility which is primarily caused by the process of aging or the infirmities of aging” (WI Statutes 51.01(5)(a)).